



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DOCTORS HOSPITAL AT RENAISSANCE  
101 PASEO DEL PRADO  
EDINBURG TX 78539

#### **Respondent Name**

GREAT MIDWEST INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-11-0430-01

#### **MFDR Date Received**

OCTOBER 4, 2010

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary Taken From the Table of Disputed Services:** "TAC Ch 134.403 and 134.404"

**Amount in Dispute:** \$2,037.23

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The carrier is escalating the disputed billing for re-audit. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). The carrier challenges whether the charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive Ogden & Latson, 504 Lavaca, Suite 1000, Austin, TX 78701

### **SUMMARY OF FINDINGS**

| Dates of Service                                  | Disputed Services                    | Amount In Dispute | Amount Due |
|---|--------------------------------------|-------------------|------------|
| February 12, 2010<br>Through<br>February 15, 2010 | Inpatient Hospital Surgical Services | \$2,037.23        | \$2,037.20 |

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated April 26, 2010

- 45– (45)– CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT
- BL– THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH FOR QUESTIONS REGARDING THIS ANALYSIS PL

Explanation of benefits dated June 28, 2010

- BL– THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL
- BL– ADDITIONAL ALLOWANCE IS NOT RECOMMENDED AS THIS CLAIM WAS PAID IN ACCORDANCE WITH STATE GUID
- 45– (45)– CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT
- 45– (45)– THIS LINE WAS INCLUDED IN THE RECONSIDERATION OF THIS PREVIOUSLY REVIEWED BILL

### **Issues**

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

### **Findings**

1. 28 Texas Administrative Code §134.404(e) states that: “Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
  - (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
  - (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.”

No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that “The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
  - (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
    - (A) 143 percent; unless
    - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.”

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is DRG 575, and that the services were provided at Doctors Hospital At Renaissance. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$9,355.26. This amount multiplied by 143% results in a MAR of \$13,378.02.
4. The division concludes that the total allowable reimbursement for the services in dispute is \$13,378.02. The respondent issued payment in the amount of \$11,340.82. Based upon the documentation submitted, additional reimbursement in the amount of \$2,037.20 is recommended.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,037.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October 29, 2012  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**